Acceptance of Restriction Request

Insert Client Name and Address	Medicaid ID# or Soc. Sec. #
	Date Filed
	Date Processed

Dear (Client name):

Thank you for submitting your request for restriction to your health information.

❒ Your request has been accepted in full. The appropriate restriction to your protected health information and/or record has been made to your _____ record.
(ie. eligibility, medical)

❒ Your request has been accepted in part. You will receive a separate letter about the area of your request that was denied.

❒ Please contact _____ to schedule an appointment to discuss the health information you requested to restrict.

❒ Other: _____

Sincerely,

Name
Job Title

c: Case File

Sample Form: The Program / Office mailing address must be added.